Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living &
Department for Behavioral Health, Developmental and Intellectual Disabilities

Kentucky Participant Directed Services
Employee/Provider Contract

I (*employee name*) _____, have agreed to work under the employment of

(*employer name)* _____.

Services under this contract will consist of the following:

SERVICE PROVIDED	**RATE PER HOUR**

Services Available Through the Participant Directed Services:

Community Access
Community Guide
Day Training
Personal Assistance
Respite
Shared Living
Supported Employment
Transportation

As an employee:

I agree to provide the above listed services as required by my employer at the rate stated above per hour.

I understand there may be civil or criminal penalties if I intentionally defraud the Department for Medicaid Services.

I understand that I shall not be approved as a Participant Directed Services (PDS) provider if results from my background check reveal that I have pled guilty to or been convicted of committing an offense as outlined in 907 KAR 12:010, Section 3 (3).

I understand that I shall not be approved as a PDS provider if I am registered on the Kentucky Nurse Aide abuse registry.

I understand that I shall not be approved as a PDS provider if results from the Central Registry Check reveal that I have been substantiated for abuse.

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I understand that under KRS 205.5607 (Kentucky Independence Plus Through Consumer Directed Services Program) Workers Compensation (KRS Chapter 342) shall not apply to my employment as a Participant Directed Services provider. This means that neither the state, nor any state agency, nor political subdivision, nor any fiscal intermediary, nor representative, nor service advisor can be held liable for any injuries or losses I may incur while providing services.

I understand that I shall not be approved as a PDS provider if results from my drug screening reveal a positive drug test as outlined in 907 KAR 12:010.

I understand that if I do not complete all training that is required with the specified timelines, I will no longer be eligible for employment with the participant.

I understand that I must maintain employee/employer confidentiality.

I understand this is an at-will contract and either party may terminate this agreement at any time.

I understand that I must notify my employer of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.

I agree to follow all relevant state and federal statutes and regulations.

I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer and myself.

As an employer:

I understand that I may be responsible for payments associated for employment requirements, including employee training.

I understand that I can only require my employee to assist with duties that are relevant to my needs and outcomes that are specified on the Plan of Care.

I understand that I may be responsible for payment for any hours I may require my employee to work beyond the authorized amount in the Plan of Care.

_____ _____

Employee/Provider Date Employer/Participant Date